## RESIDENT CONTROLLED MEDICATION ACCOUNTABLITY RECORD

Resident:				Resident's Rm. #:	Physician:Phone#:		Phone#:Prescription #:		
Pharmacy:									
Medication name:				Dosage:	Frequency:		Method:	Number of Refills:	
Date Medication Received:				Date Reordered (if applicable):			Date Discontinued:		
*Disposit	ion of Re	maining I	Ooses (Giver	to a family member or responsible	individual or ret	ırned to Pharn	nacy for destruction):_		
Signature	gnature of TWO witnesses of disposition:/								
DATE	TIME	Amt RECD	Amount Given	Medication Assistance Provided By:	Amount Left	OFF Duty Count	OFF Duty Signature	ON Duty Count	ON Duty Signature

<sup>\*</sup>Two signatures are required when witnessing any disposition of Controlled Medication. DPHHS-QAD Created 2/28/0